STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews, the facility failed to ensure that one resident (#11) was discharged in a manner that prevented accident hazards. The deficient practice resulted in a resident being inadvertently discharged with a Peripherally Inserted Central Catheter (PICC) line in place, which could pose a risk of infection or potential misuse of the PICC line.Findings include:Resident #11 was admitted to the facility on [DATE] with diagnoses that included encephalitis and encephalomyelitis, extradural and subdural abscess, alcohol abuse with withdrawal, and generalized muscle weakness.Review of the care plan revealed a problem focus, dated April 19, 2025, which revealed that Resident #11 was receiving IV antibiotic medication. The goal in place for this focus was that the resident would not have any complications related to IV therapy. Interventions included administering IV per order via PICC line, changing the dressing per order, usage of EBP during high-contact care, and monitoring/documenting/reporting/ any signs of infection at the site.Review of the physician orders revealed the following orders:Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenously one time a day for CEREBRITIS until 05/20/2025 23: 59 - (Ordered 4/19/25)Discontinue IV/PICC line after completion of IV ABX and provider approval. one time only for ABX for 1 Day - (Ordered 4/19/25)Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS also indicated that Resident #11 was receiving IV medications while a resident.Review of the NP note dated May 19, 2025 revealed that Resident #11 was receiving IV antibiotics with an anticipated end date of May 20, 2025.Review of a Medication Administration Note dated May 20, 2025 revealed that Resident #11's end date for his ordered Ertapenem was May 20, 2025. The note indicated that pharmacy would need an updated order to continue this medication, and that the provider was notified of this.Review of the discharge summary indicated that Resident #11 was discharged to the community and to his private home or apartment on May 21, 2025 at 8:00AM. The discharge summary indicated that Resident #11 was not going to receive home health services or medical equipment at home. There was no evidence found in the summary or the progress notes that the resident's PICC line was removed or was offered to be removed.Review of the Discharge MDS, dated [DATE], revealed that Resident #11 was not receiving any IV medications at discharge.Telephone interview was conducted on July 1, 2025 at 11:34AM with Resident #11, who confirmed that he was discharged from the facility with his PICC line still in his arm. The resident also claimed that he had told staff that he needed his PICC line removed while preparing to discharge, but the resident stated that he felt the staff were rushing him to discharge home and failed to remove it. Resident #11 also explained that he did not know what to do with the PICC once home. He explained that he could not shower because he knew he could not get the PICC line wet. The resident also stated that he eventually went to the hospital closest to him to get it addressed, though it took him several days to make arrangements to go to the hospital. The resident expressed frustration at the situation, and stated that he did not believe the facility assisted him at all with removing the PICC line or the costs associated with his subsequent hospital visit.Interview was conducted on July 1, 2025 at 1:04PM with a Licensed Practical Nurse (LPN/Staff #4), who stated that PICC lines should always be removed before discharging a resident, especially if they have drug-seeking behavior. The LPN identified the risks of discharging a resident without removing their PICC line to be that it is an infection risk, and the resident could put drugs into the PICC line. The LPN denied ever discharging a resident with a PICC still in place, but she thought it may have happened because she recalled receiving an in-service training about it recently.Interview was conducted on July 1, 2025 at 2:06PM with the Director of Nursing (DON/Staff #26), who stated that doctor's orders should be followed when determining if a resident can discharge with a PICC line or not. When asked about Resident #11, the DON stated that Resident #11 was not supposed to discharge with his PICC in place, and there were orders in place to remove the PICC line. The DON stated that Resident #11's family was rushing to leave with the resident. The DON also stated that the nurse had attempted to convince the resident to stay so that the PICC could be removed, but the family insisted on leaving. The DON explained that there was not an RN in the building at the time that the resident was trying to discharge with family, so the nurse had attempted to convince them to wait until an RN arrived to remove the PICC. When asked when the facility discovered that the resident discharged with the PICC, the DON stated that the resident reached out to the facility shortly after discharging. The DON explained that the